Diabetes Disease Mgmt: Getting Started!

CDR Padden

Special Thanks to:
CAPT Jackson
Ms Marullo
CAPT Williams

How many of you have previously been involved with unsuccessful disease management efforts?

Why were these efforts unsuccessful?

Objectives

- Consider the roles/training of the multidisciplinary members of your team
- Differentiate carved-in and carved out models of disease management
- Examine the importance of patient self-management and the PCM relationship

New Age for Navy Medicine: BUMED Business Planning?

Reorganization

Comparison across MTFs

Setting the Stage

- BUMED Business Plan mandates implementation of disease management
- Diabetes performance metrics identified
  - Modest expectations in beginning
- MTF C.O. Report cards
- Population Health Navigator (PHN) the accepted information source
- Diabetes Action Team (DAT): Accepted the DOD VHA Diabetes CPG & Toolkit

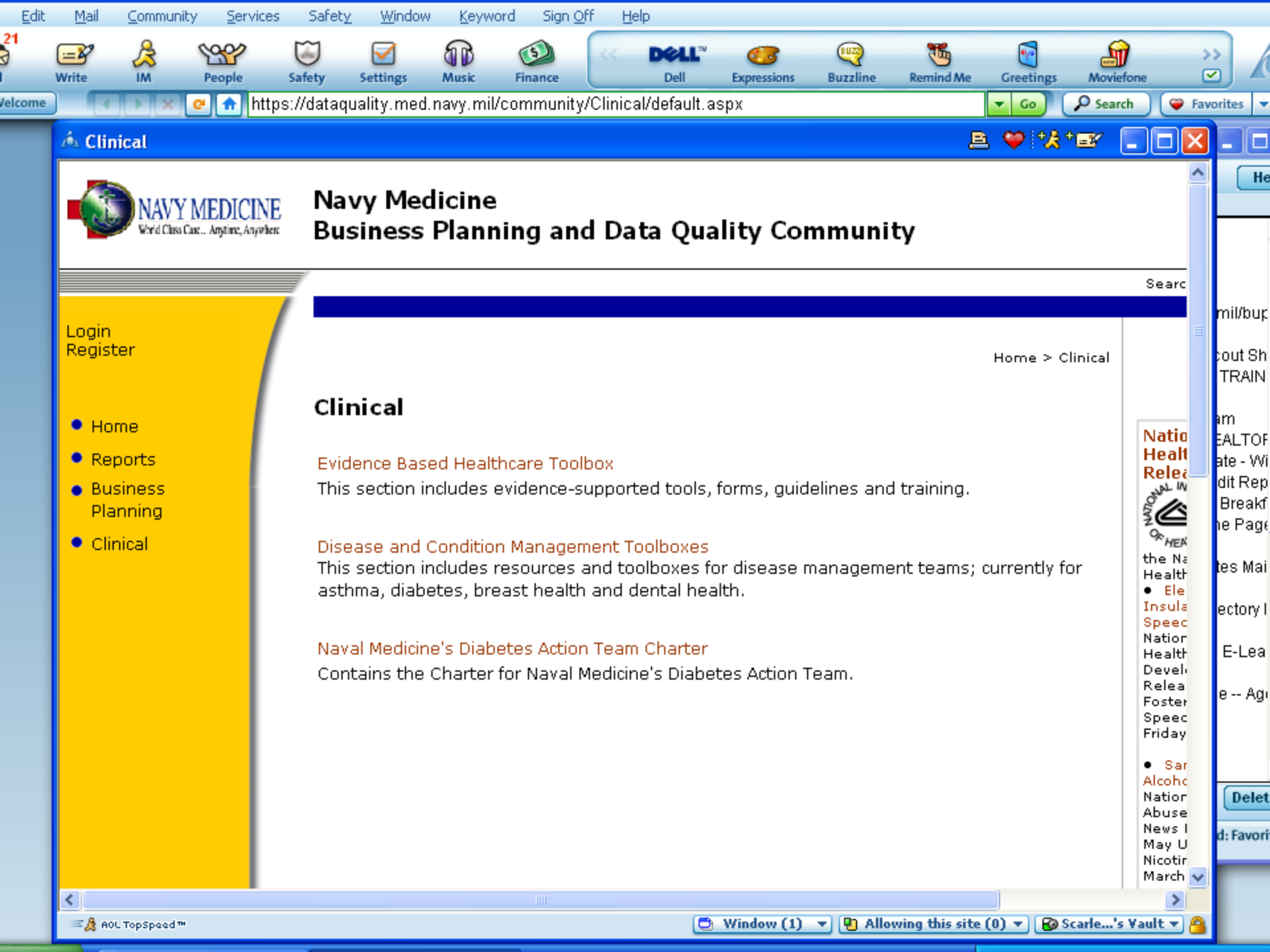
BUMED Note 6310

- Outlines system-wide expectations and guidelines for diabetes management
- Clinical and Administrative Champions
  - Population Health Navigator (PHN)
    - Clinical information system for identifying cohorts
- Disease Management Re-engineering
  - Identify, aggressively treat A1C > 9.0%
  - Notification of PCM if DM patient seen in ER
  - 24 hour access for DM patients

HEDIS Measures

- **Mandatory**
  - ***HbA1c***: Percent of patients with HbA1c values less than or equal to 9.0 % during the past year
  - ***LDL-Cholesterol***: Percent of patients with LDL-Cholesterol test values < 100 mg/dl *
- **Recommended**
  - Initial Assessment
  - Foot Exams
  - Retinopathy screen
  - Patient education
  - Periodic follow up

*note that current recommendations are LDL < 70 mg/dl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Evidence Based Healthcare Toolbox
This section includes evidence-supported tools, forms, guidelines and training.
Disease and Condition Management Toolboxes
This section includes resources and toolboxes for disease management teams; currently for asthma, diabetes, breast health and dental health.
Naval Medicine's Diabetes Action Team Charter
Contains the Charter for Naval Medicine's Diabetes Action Team.
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NAVY Population Health Navigator

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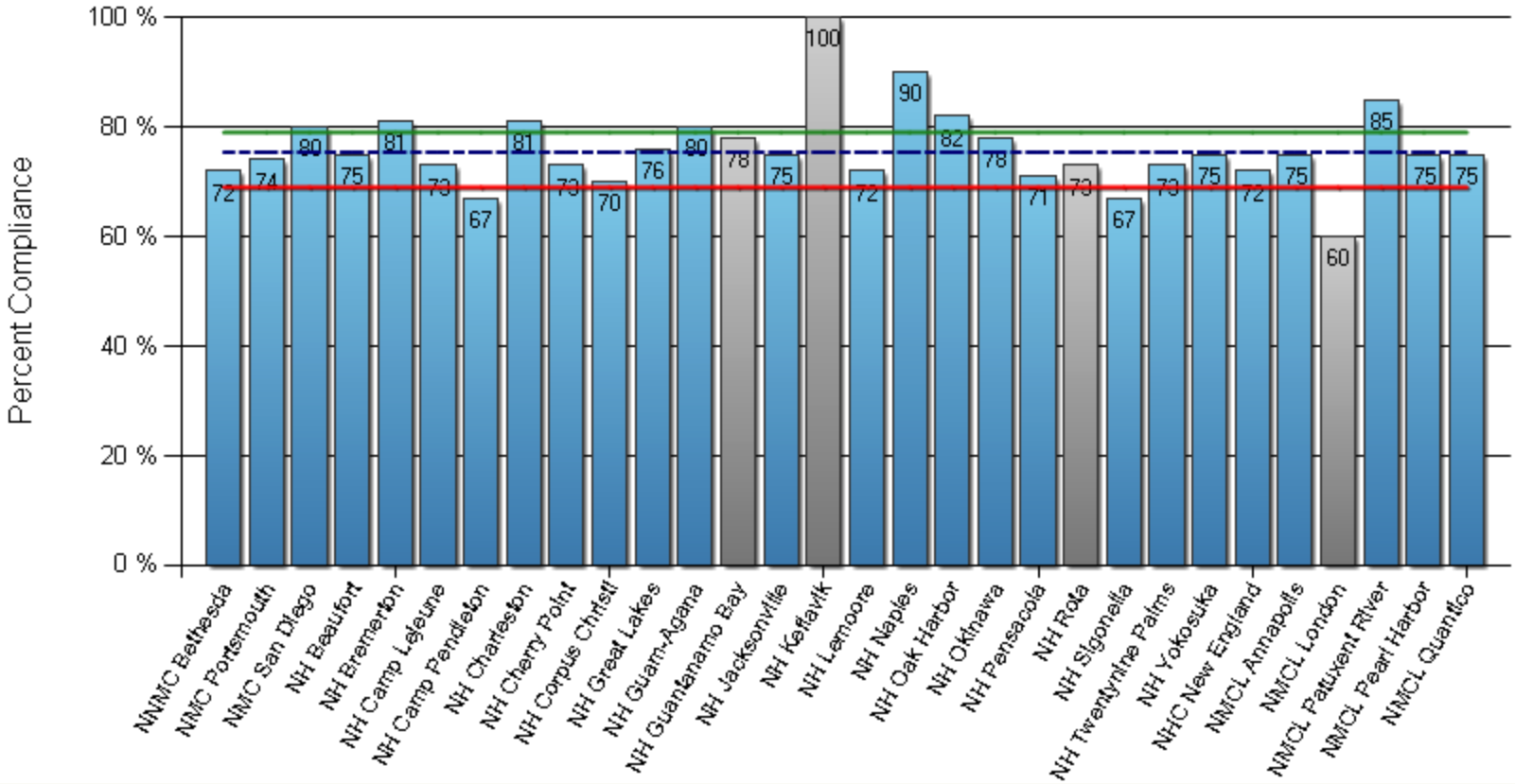
Navy Medical Facilities: January 2006

Continuously Enrolled Diabetics with A1C ≤ 9.0

HEDIS 90th Percentile: 79%
HEDIS 50th Percentile: 69%
Navy Average: 75.4%



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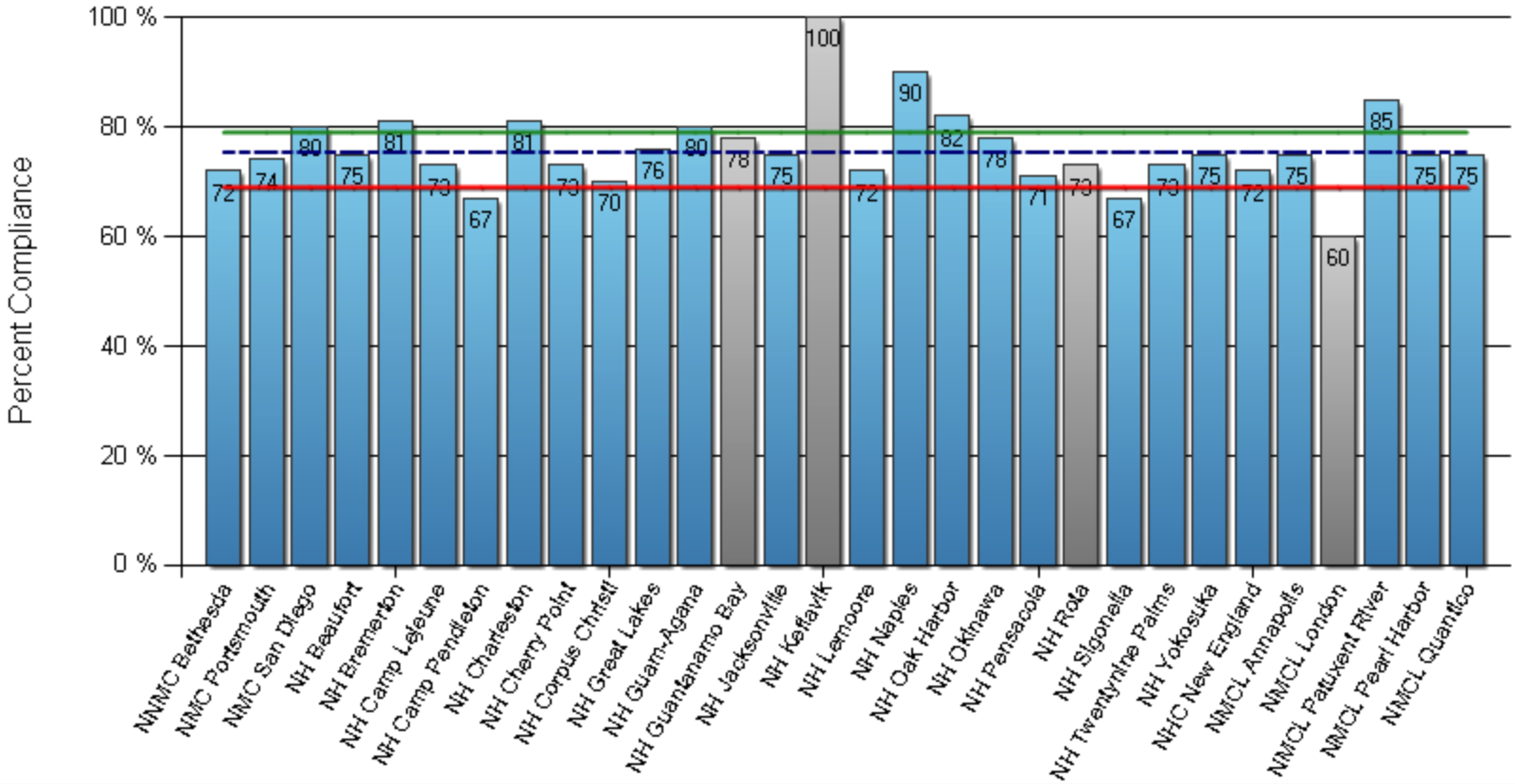

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More information than ever available at our fingertips

But you have to have a process in place to:

USE IT

REVISE YOUR OPS BASED ON CHANGES

We must move from a health care system that manages disease already rampant....

...to one that is founded in preventing disease to begin with

Assumptions

- Simply providing a CPG wont change practice
- CPG is but a small part of the big picture
- Major changes in clinical business processes must be undertaken
- Road Map facilitates process change individualized for each MTF
- Commands may discover best practices that can be shared Navy wide.

Making the MTF Roadmap Work For Your MTF

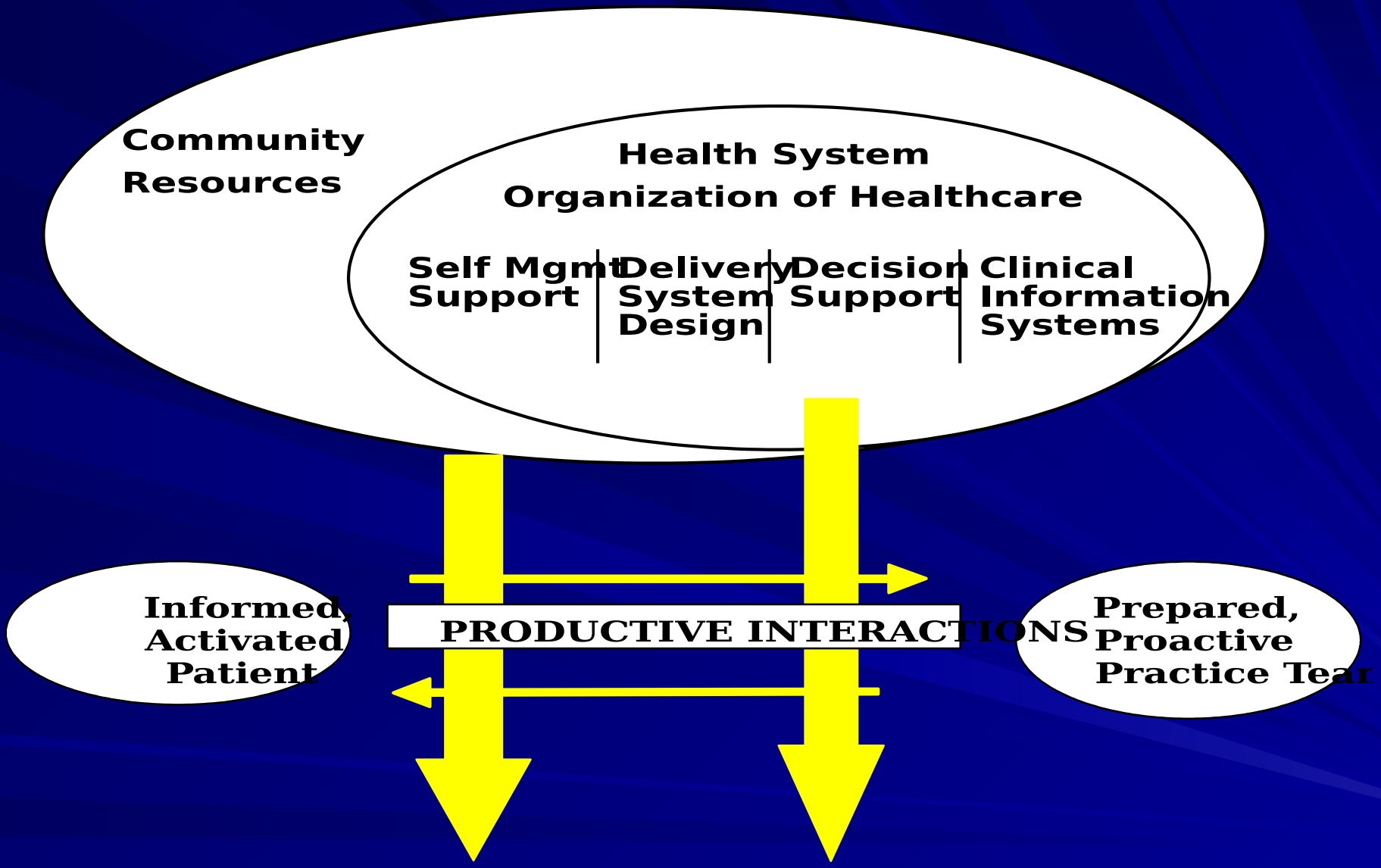
- Clear identification of disease champion and program coordinator
- Identify and maximize resources
  - CPG guidelines
  - Patient and Provider Education Toolbox
- Collaborate with Performance Improvement Team
- Provide education to health care team and patients

Disease Management Action Plan

- Functional Assessment/Gap Analysis
  - Utilize the MTF Road Map Action Plan to assess the functional requirements of your MTF
    - Leadership
    - CPG and Metrics
    - Disease Condition Management and Reengineering
    - Program Deployment and Evaluation
    - Education
- Plans to Close the Gap
  - Identify measures for improvement
  - Prioritize

Wagner Model

- Exemplifies how teams can have an impact
- Framework for examining the disease management process
- Recognizes that several areas of clinical practice must be optimized for “excellence”
- Steps beyond the CPG “quick fix”
- Stresses practice redesign, patient education and expertise of providers


Community Resources
Health System
Organization of Healthcare
Self Mgmt Support
Delivery System Design
Decision Support
Clinical Information Systems
Informed, Activated Patient
PRODUCTIVE INTERACTIONS
Prepared, Proactive Practice Tear
Functional and Clinical Outcomes

Disease Management

- “Best” programs incorporate elements of Wagner model
- Certain aspects of care are delegated
- Elements
  - Population management
  - Clinical practice guideline
  - Self-management support
  - Intensive follow up

“Clinician Basics”

- Familiarize providers and team with CPG, BUMED metrics and sources of data
- Carefully define team member roles as clinical business process is redefined
- Ensure providers have the knowledge necessary to execute high quality care
- Timely and regular feedback to providers regarding their performance is paramount

Disease Management Models

- Two different approaches:
  - Carved in model
  - Carved out model
- Choice of a model should be individualized
  - Practice style of providers
  - Needs / demands of patients
  - Resources available at the MTF

Carved-in Model

- Disease management is incorporated into Primary Care Team function
- Multidisciplinary team attends to various aspects of care
- Provider is supported with tools to ensure that patients receive high quality care
- “Right person delivers the right care” in a familiar environment

Carved-out Model

- Disease management is carved out from primary care team
- Separate disease management “teams” attend to that aspect of care
- Many HMO’s have favored such models
- Primary Care Team must maintain contact
- Specialized team can focus on high risk disease management

Carved-in versus Carved-out

Which do you think is better?

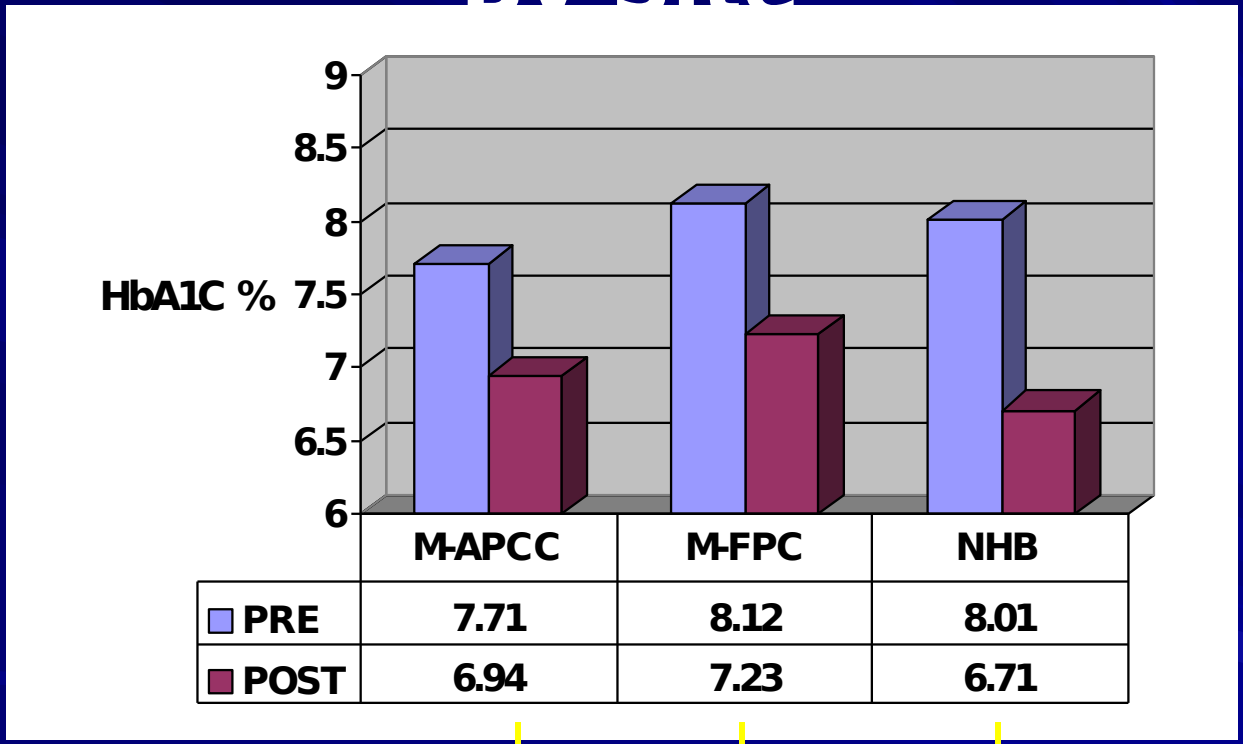
Which is a better fit for the culture of your MTF and patient population?

Let’s examine one head to head comparison in a military MTF….

Diabetes Disease Management in Tricare Region 11.

Thesis work Maureen Padden MD MPH
unpublished data

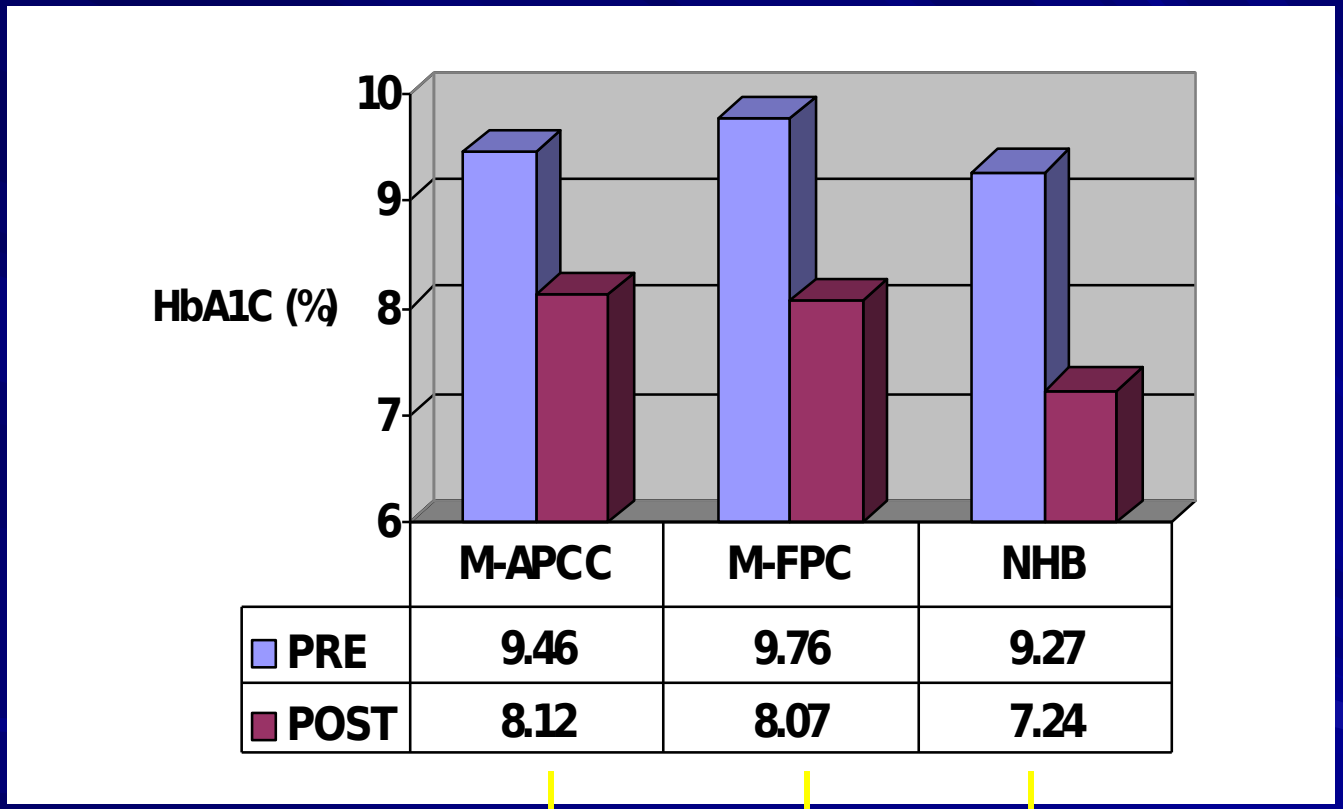
Mean Change in HbA1C (%) Overall Study Population (High and Low Risk) By Site



Net Change: - 0.77 % - 0.89 % - 1.3%

Unpublished research data Padden, MO

Mean Change in HbA1C (%) High Risk Cohort by Site

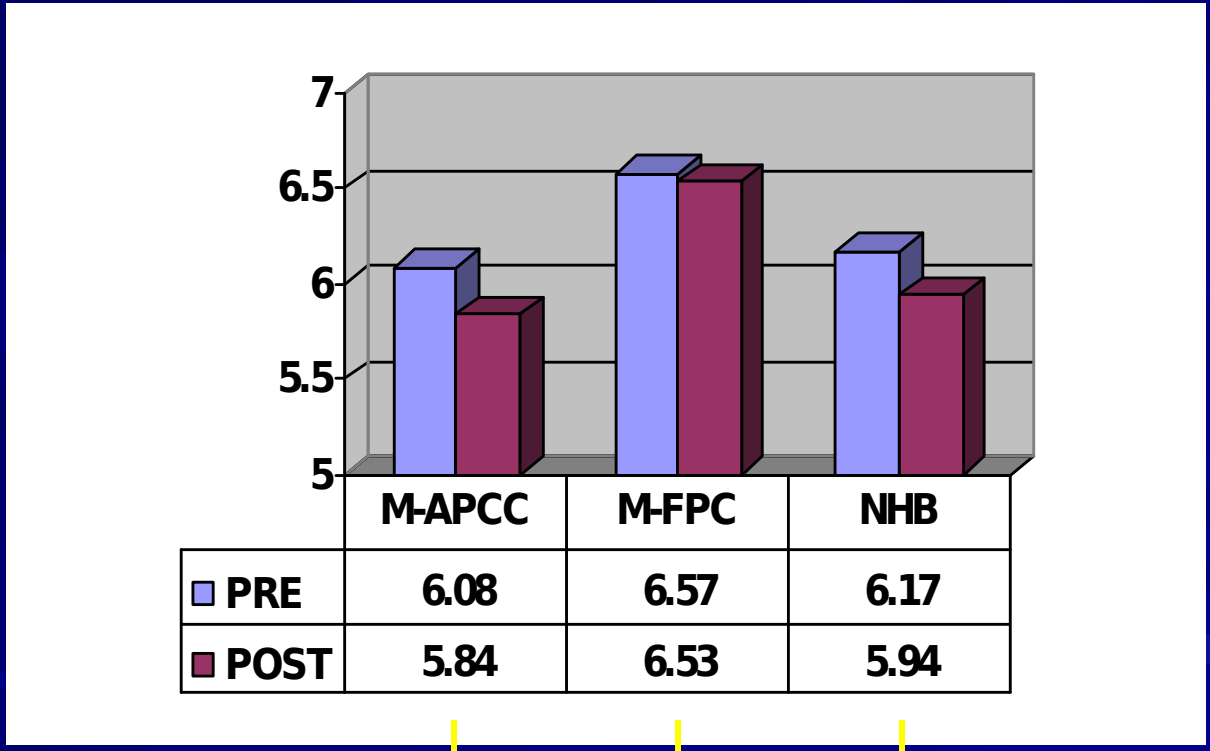


Net Change: **- 1.3 %** **- 1.7 %** **-2.0 %**

Unpublished research data Padden, MO

Mean Change in HbA1C (%)

Low Risk Cohort by Site



	M-APCC	M-FPC	NHB
PRE	6.08	6.57	6.17
POST	5.84	6.53	5.94

Net change: - 0.24 % - 0.04 % - 0.23 %

Unpublished research data Padden, MO

Other findings...

- Every other metric improved.
- Both models were effective
- Each portal of care preferred their own model
- Carved in was slightly better
- Endocrinology visits were cut in half
- Results led to improved resourcing

So why have DM efforts failed?

- Over-reliance on the Clinical Practice Guidelines (CPG's) as the cure-all
- Physician adherence often falls short
- Providers report time constraints at fault
- Deny the need for help, even in the face of evidence to the contrary
- Patient "non-compliance" is the default

Patient Compliance

"The extent to which a person's behavior coincides with medical or health advice"

The problem with compliance...

- Gives no credence to the patient's role
- Implies patients simply follow directions
- Adherence is a better term
  - Characterizes patients as intelligent, independent
  - Encourages active and voluntary role
  - Patients help to define and pursue goals
- Adherence assumes patients to be equal partners

Successful Disease Management

- Partnership between provider and patient
- Self-regulation changes patients behavior and improves health status
- Patient should be their own Primary Care Manager (PCM)
- Provider assists in establishing the best therapeutic plan for the individual patient
- The team adjuncts their support

Patient Self Management

- Patients need survival skills between visits
  - Instruction on use of glucometer
  - Use of medication
  - Action plan for hypoglycemia
  - Action plan for hyperglycemia
  - Nutrition management (Carb counting!)
  - Physical activity plan
  - Sick day management

Diabetes Education Toolbox

- Includes survival skills for patients
- Powerpoint educational presentations for patient education
- Train the trainer tools
  - Powerpoint presentation to train providers
  - Competency training tools
- What things do you think should be in there?

Patient Self Management

- An often overlooked aspect of chronic disease management
- Besides teaching, patients need support in between visits from families and friends
- Chronic Disease Self Management Program developed at Stanford
  - Patients in this program managed their overall health better than those not in the program
  - Teaches patients coping skills
  - The AA of chronic disease self management

Importance of PCM relationship

- Regular Source of primary care is associated with improved glycemic control
- Sustained relationship may result in increased trust and willingness to follow providers advice
- Follow up in the ER is more expensive and less effective
- Keep the care at the most appropriate level

The Highly Trained PCM Team

- Highly trained PCM teams are powerful:
  - Reduce unnecessary and costly ER visits
  - Limit specialty consultation to those cases needing their expertise
  - Learn how to provide the care they have overlooked, deferred or referred in the past
  - Improve health outcomes for their patients
  - Seek information from important liaisons such as Tricare to continually improve care

Bottom Line

- Program must be integrated into MTF clinical processes in a way that works
- PCM centered
- Multidisciplinary team planning must occur
- Program should be resource based
- Program should strive to create a more educated provider force

What do you see as major obstacles to implementing Disease Management in your Facility?

What is your first step when you head back home?

Questions?